State Action Plan Table

State: Maryland

Priority Need: Optimize the health and well-being of girls and women across the life course using preventive strategies.						
Objectives	**National Outcome Measures**	**National Performance Measures**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**
By 2020, reduce the low risk cesarean delivery rate by at least 10% from the 2013 baseline of 30.8% (MVSA)	Severe maternal morbidity per 10,000 delivery hospitalizations(HSCRC) Maternal death rate per 100,000 live births (NVSS)	NPM 2: % of low risk cesarean deliveries among low risk first births (NVSS)	Support MD Perinatal-Neonatal Quality Collaborative in efforts to identify areas of improvement and implement strategies to reduce cesarean deliveries Participate in Alliance to Improve Maternal Health (AIM), Primary C-Section Reduction Monitor very low birth weight and neonatal mortality rates by birth hospital neonatal level of	% and # of birth hospitals participating in collaborative that prioritize low risk cesarean reduction % and # of hospitals that receive technical assistance (including data on individual hospital rates, ACOG guidelines, and policies/strategies) on low risk cesarean reduction % and # of very low birth weight births at level I and II hospitals (MVSA)	% of hospitals that integrate service practices/ policies to support the reduction of low risk cesarean deliveries	# of low risk cesarean deliveries (MVSA)

			care via MVSA			

Priority Need: Improve perinatal and infant health in Maryland by reducing disparities.						
Objectives	**National Outcome Measures**	**National Performance Measure**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**
By 2020, reduce the Black/White gap in infant mortality by 10%	Infant mortality per 1,000 live births (NVSS) Neonatal	NPM 5: % of infants placed on their back to sleep (PRAMS)	Educational Safe Sleep Campaign in Baltimore City, integrated in hospital perinatal services	# of hospitals that integrate safe sleep educational services within perinatal services	# and % of infants placed on backs to sleep (PRAMS)	# of SUIDs (NVSS) Rate of infant mortality (NVSS) Average length of

from the 2013 baseline of 2.3 (NVSS) By 2020, increase the % of infants placed on their back to sleep to 80% (current baseline is 77%; 2012 PRAMS Survey) (PRAMS) By 2020, increase the % of Black infants placed on their back to sleep to 66% (current baseline is 63%; 2012 PRAMS Survey) (PRAMS)	mortality per 1,000 live births (NVSS) Post neonatal mortality per 1,000 live births (NVSS) Sleep-related SUID mortality per 1,000 live births (NVSS)		Concentrate educational resources in communities of greatest need Conduct parental interviews for SUID cases to inform future safe sleep efforts Encourage the use of most effective contraception options Support the MD Perinatal-Neonatal Quality Collaborative in efforts to standardize identification, evaluation, treatment, and discharge management of infants with NAS	# and type of communities that receive safe sleep educational resources # of interviews conducted # of Title V grantees providing most effective contraception options to women of childbearing age % and # of birth hospitals participating in the collaborative that prioritize standardization of care for infants with NAS	% and # of hospitals that integrate service practices/ policies to improve the quality of care for substance exposed infants	stay for infants born with neonatal abstinence syndrome (NAS) (HSCRC/Collab) Average length of time on medication management for infants born with NAS (HSCRC/Collab)

Priority Need: Improve access to preventive, primary, specialty and behavioral health services as well as medical homes for Maryland children including those with special health care needs.						
	National Outcome	**National Performance**	**Evidence Based or**	**Evidence Based or Informed Strategy**	**State Performance**	**State Outcome**

Objectives	Measures	Measure	Informed Strategy	Measures	Measures	Measures
By 2020, increase the % of children, ages 10-71 months, receiving a developmental screening by at least 10% from 2011/12 baseline of 31.8% (NSCH) By 2020, increase the % of children with a medical home by 10% (baseline of 57.2% in 2011/2012) (NSCH) Increase screening and diagnostic services for behavioral health (data and baseline TBD)	Percent of children in excellent or very good health (NSCH) Percent of children meeting the criteria developed for school readiness (MSDE)	NPM 6: % of children, ages 10-71 months, receiving a developmental screening using a parent completed screening tool (NSCH)	Educate parents/ caregivers about resource/service availability Track developmental screening rates, and disparities when possible, across early childhood systems Disseminate “Birth to 5: Watch me Thrive” materials statewide to parents and other stakeholders via web Partner with AAP, MSDE, Medicaid, MIECHV (HV programs) in their efforts to improve screening rates	# of parents that received screening tools (LHDs) # of parents that receive screening educational materials (LHDs)	% of Medicaid patients, age 15 months, who had 5 or more well child visits during the first 15 months of life (Medicaid)	% of children, ages 10-71 months, receiving a developmental screening (NSCH)

Priority Need: Improve the health and well-being of adolescents and young adults in Maryland including those with special

health care needs by addressing risk behaviors.						
Objectives	**National Outcome Measures**	**National Performance Measure**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**
Increase the percentage of adolescents receiving preventive well visits from baseline of 85% in 2011/12 to 88% in 2020 (NSCH) Develop one State Plan to improve adolescent health	Percent of adolescents in excellent or very good health (NSCH) Rate of death in adolescents 12-20 per 100,000 (NVSS) Percent of adolescents in grades 9-12 who used tobacco (YTRBS) Percent of adolescents with mental health problems who receive treatment (NSCH)	NPM 10: % of adolescents with a preventive services visit within the past year (NSCH)	Develop an Adolescent Health Strategy for the State Through participation in AYAH CoIIN, collaborate with stakeholders to identify/ track a set of measures related to access to and quality of adolescent preventive care, and use the measures to drive improvements Partner with individual Local Health Improvement Coalitions to increase receipt and quality of adolescent well visits in local jurisdictions Collaborate with current State adolescent initiatives (e.g.,	Adolescent Health Strategy developed # of adolescent health measures re- access and quality of care identified/ tracked # of Local Health Improvement Coalition partners # of relevant OFCHS programs that integrate positive youth development	% of Medicaid patients, ages 11-18, who received a mental or behavioral health screen in the past year (Medicaid)	Improved health status of adolescents (NSCH)

			Medicaid, school health, Chronic Diseases, Immunizations, Injury prevention, reproductive health, substance abuse, mental health) through the AYAH CoIIN Promote positive youth development principles across state funded adolescent health programs			

Priority Need: Improve the health of children and youth with special health care needs.						
Objectives	**National Outcome Measures**	**National Performance Measure**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**
Medical Home: Increase by 5 % the percentage of CSHCN and	Systems of care for children with special health care needs: percent of children and	NPM 11: % of children with and without special health care needs having a	Assess state of care coordination in Maryland Develop statewide model of care coordination based on	# of CYSHCN who receive patient and family centered care coordination services	% of families who report being satisfied with their child's care coordination services	# of children who receives care coordination services

their families who have access to appropriate patient and family centered care coordination by FY 2020 By 2020, evaluate parent involvement with care coordination	youth with special health needs receiving care and in a well-functioning system	medical home	findings and support implementation through a standardized framework Support the expansion and implementation of CYSHCN regional liaison roles to additional regions throughout the state of MD to facilitate partnership and coordination between regions Include a comprehensive shared plan of care component as a Target Area in the Office grants program. Provide technical assistance to grantees on how to implement. Strengthen our Family Professional Partnership Unit by	# of providers who participate in statewide inventory and mapping care coordination services # of families who report being satisfied with their child's Care Coordination services # of CYSHCN who have a developed care plan		

services in Maryland and increase parent satisfaction with care coordination by 5% Expand stakeholder			implementing a client satisfaction parent feedback and evaluation component, to measure quality of services of office funded grant projects. Support grantees and practices with technical assistance on developing and implementing family engagement activities. Facilitate regional family focus group focused on care coordination and parent satisfaction. Conduct state-wide MD Parent Survey	# of parents who participate in MD parent survey and feedback evaluations # of individuals OGPSHCN trains about family engagement, cultural competency, and family sensitivity # of parents/families that report being able to access community-based services		

collaboration of care coordination for CYSHCN by creating an implementation team to identify best practices that can translate into consistent implementation strategies used by a variety of service providers by 2020			Utilize Maryland Community of Care Consortium (COC) and Care Coordination implementation team to vet input from diverse stakeholders, support existing initiatives, and collaborate around Medical Home implementation and improve systems of care for CSHCN	# of identified OGPSHCN partners who attend and participate in COC (Community of Care) and Care Coordination implementation team meetings		
Maintain follow up procedures to track infants who missed or did not pass the birth hearing screening through 2020 so that LTF/D			Implement QI strategies including face to face visits with medical home providers in target regions where loss to follow up/ documentation rates are highest	% of infants who are LTF/D who did not pass an initial hearing screen		

does not exceed 17%			In collaboration with Maryland's Home Visiting and WIC programs, track and locate LTF/D infants and provide resource information to the families about the benefits of performing a hearing screen and address their concerns			
Increase access to specialty care services for CYSHCN in underserved areas through partnerships with the Kinera Hub on the Eastern Shore, to establish a facility and expand service offerings progressively in to 2020			Increase the capacity for rural areas to regionalize services for CYSHCNthrough the eastern shore regional hub model targeted to specific local needs Update, maintain, and improve accessibility to CYSHCN resource locator database; Develop and promote platforms and mechanisms that will allow for accessibility of resources and services	# of clients who access the Eastern Shore Regional Hub for specialty care # of new identified services added to OGPSHCN resource locator database yearly # of resource locator users		

Provide education to health care professionals using the National Center for Medical Homes implementation guide through regional trainings at 13 local health departments by 2020			In collaboration with the Maryland Office on Oral Health, increase awareness about oral health issues impacting CYSHCN and develop an education plan around oral health for children with special health care needs Provide training and technical assistance to to private and public health workforce to effectively and efficiently address care coordination Develop a group of stakeholders/interested parties focused on efforts to secure full insurance coverage for un-insured CSHCN.	# of health service providers that received training and technical assistance support for Medical Home implementation		
Youth Transitioning into Adulthood: Increase by 10% the number of CSHCN	Percent of adolescents with and without special health care needs who have received the services	NPM 12% of adolescents with and without special health care needs who received services necessary to	Engage youth and their families by leveraging the power of social media tools and focus groups to disseminate resources and information as well as gather input on HCT	#of YSHCN and families who participate in transition planning activities	# CSHCN families who report participating in transition planning activities for their YSHCN	# of youth who successfully transition from adolescent to adult health care

families who are participating in health care transition planning for their YSHCN by 2020	necessary to make transitions to all aspects of adult life, including adult health care, work, and independence	make transitions to adult health care	Utilizing the 6 Core Elements, develop educational materials and tools in multiple languages that introduce Health Care Transition and highlight the importance of family participation and planning of HCT for CYSHCN Participate on the Governor's Interagency Transition Council (IATC) to ensure information and resource access			

Assess the number of YSHCN ages 12-17 who have a transition readiness assessment and comprehensive plan of care in order to increase the			Through OGPSHCN program grants, partner with and support pediatric, adult, LHD and academic tertiary care centers in efforts to include family participation and planning into HCT activities and services Collaborate and partner with Maryland State Department of Education and other school based health care teams (School Nurses and administration, IEP coordinators) provide training seminars and technical assistance Promote and encourage the use of the Got Transitions HCT policy, care plan and readiness assessment tools in collaboration with school health, F2F and other family agencies	# of YSHCN who have completed a transition readiness assessment # of facilities/agencies using a HCT policy, care plan and readiness assessment			

number from the identified baseline by 5% in 2020			Provide expertise, tools, resources and technical assistance to pediatric health care, youth, and family service providers as well as other state and local agencies on adoption and implementation of the standard transition readiness assessment			
Develop and implement a comprehensive outreach and education plan to increase awareness and support of HCT among different audiences by 2020			Utilize the Maryland Health Care Transition Leadership Team to address HCT challenges, provide solutions, share best practices and shape policy and practice to improve the quality and delivery of services Conduct trainings and presentations for pediatric and adult health care providers and staff who provide transition services to YSHCN. The use of training webinars and CMEs will be utilized to engage providers	# of individuals that receive training and education on HCT # of community events, presentations, meetings in which participants received education around Health Care Transition		

			Develop a brochure that introduces Title V CSHCN and HCT that is available to adult and primary care providers across the state Provide education on condition-specific HCT milestones to youth and families at local HCT events Explore best practices used by hospitals/special care centers for disease-specific transition milestones and activities to add to care plans Based on findings, create educational materials for condition-specific milestone activities for transitioning youth			

Priority Need: Improve the oral health status of MCH populations across the lifespan.						
Objectives	**National Outcome Measures**	**National Performance Measure**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**

By 2020, increase the % of women who had a dental visit during	Child Health Status (% of children in excellent or very good health)	NPM 13A: % of women who had dental visit during pregnancy (PRAMS)	Survey/interview medical and dental providers, pregnant women and WIC staff about oral health knowledge,	Survey/interview findings of medical and dental providers, pregnant women, and WIC staff	# of pregnant women surveyed/ interviewed on barriers and facilitators to	% of children ages 1-6 who have decayed teeth or cavities in the past 12 months (NSCH)

pregnancy by 10% (PRAMS) Increase the % of children who had a dental visit in the last year to 90% by 2020 (NSCH) By 2020, determine barriers and facilitators to dental care of low-income pregnant women throughout MD (OOH) By 2020, develop MD state oral health during pregnancy and infancy practice guidelines for medical and dental professionals, and disseminate statewide (OOH)	(NSCH)	NPM 13B: % of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year (NSCH)	practices and barriers and facilitators to care Oral health during pregnancy social marketing campaign targeting Hispanic women of childbearing age Education and training of OBGYNs and dental providers Partner with Office of Oral Health (OOH) to implement the Perinatal and Infant Oral Health QI (PIOHQI) grant Promote the MD Medicaid Helpline for pregnant women that assists women in accessing oral health care during pregnancy Continue oral health social marketing campaign for young children Partner with the OOH, Medicaid and	# of Hispanic women who receive targeted messages (impressions) # targeted messages developed and disseminated # of social media outlets # of OBGYN and dental providers who receive state oral health during pregnancy and infancy guidelines and training # of local health department staff trained and who received oral health resources # of partners in the PIOHQI collaborative	dental care (OOH) # of referrals of pregnant women (who called the MD Medicaid Helpline for pregnant women) to local health departments for assistance in finding a dentist (Medicaid) # and % of WIC sites that provide oral health information and educational materials to clients (OOH)	# of women who receive dental care during pregnancy (PRAMS) # of infants and children, ages 1-17 years, who receive dental care once within 12 months (NSCH)

			others to increase use of preventive services Provide training and oral health resources to LHD administrative care coordination unit (ACCU) staff on oral health during pregnancy			

Priority Need: Reduce substance use/abuse (including tobacco, alcohol, prescription drugs, and opioids) across the lifespan for MCH populations						
Objectives	**National Outcome Measures**	**National Performance Measure**	**Evidence Based or Informed Strategy**	**Evidence Based or Informed Strategy Measures**	**State Performance Measures**	**State Outcome Measures**
Reduce the % of women smoking during pregnancy by 10% by 2020 (baseline of 7%; 2012 PRAMS Survey) Increase # of referrals from providers to	Severe maternal morbidity Maternal mortality LBW & VLBW rates Preterm, early preterm &	NPM 14A:% of women who smoke during Pregnancy NPM 14B:% of children who live in households where someone smokes	Connect women of childbearing age and pregnant women to services and incentives offered to them when they call the Quitline Offer incentives to women who call the Quitline and complete calls with a counselor	# of pregnant women using the Quitline # of pre-delivery incentives and post-partum incentives awarded # of referrals to the Maryland Tobacco Quitline	# pregnant women enrolled in local health tobacco treatment programs # of Maryland local health departments who offer in person smoking	# and % of women who smoke during pregnancy (NVSS) # and % of women who remain tobacco free post- partum (PRAMS)

Maryland Tobacco Quitline by 5% Increase the # of calls from pregnant or postpartum women to the Maryland Tobacco Quitline by 5% Increase access to services for alcohol and substance abuse treatment, and smoking cessation for women of childbearing age and pregnant women Prevent/reduce substance use/abuse among teens	late preterm rates Early term birth rate IMR and related measures % of children in excellent or very good health		Collaborate with Legal Resource Center and MD Landlords on ways to make apartment buildings smoke free Connect women of childbearing age and women who breastfeed to Quitline services Partner with CTPC to reduce household smoking Develop annual health communications plans including interventions with call to action: “Call the Maryland Tobacco Quitline” or “Visit smokingstopshere.com”	# of health communication interventions and/or media campaigns implemented # of “point of care” campaign impressions # of teens between the ages of 13-17 who have received smoking cessation assistance # of pregnant women counseled	cessation assistance	# and % of children who reside in smoke-free households (NSCH)